IDAHO DEPARTMENT OF
HEALTH & WELFARE

C. L. "BUTCH" OTTER, GOVERNOR
RICHARD M. ARMSTRONG, DIRECTOR

DEBBY RANSOM, R.N., R.H.I.T – Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, Idaho 83720-0036
PHONE: (208) 334-6626
FAX: (208) 364-1888
E-mail: fsb@idhw.state.id.us

May 17, 2010

Rex Redden
Idaho Falls Group Home #3 Periska
P.O. Box 50457
Idaho Falls, ID 83405-0457

RE: Idaho Falls Group Home #3 Periska, provider #13G045

Dear Mr. Redden:

This is to advise you of the findings of the Medicaid/Licensure survey of Idaho Falls Group Home #3 Periska, which was conducted on May 6, 2010.

Enclosed is a Statement of Deficiencies/Plan of Correction Form CMS-2567, listing Medicaid deficiencies and a similar form listing State licensure deficiencies. In the spaces provided on the right side of each sheet, please provide a Plan of Correction. **It is important that your Plan of Correction address each deficiency in the following manner:**

1. Answer the deficiency statement, specifically indicating how the problem will be, or has been, corrected. Do not address the specific examples. Your plan must describe how you will ensure correction for all individuals potentially impacted by the deficient practice.

2. Identify the person or discipline responsible for monitoring the changes in the system to ensure compliance is achieved and maintained. This is to include how the monitoring will be done and at what frequency the person or discipline will do the monitoring.

3. Identify the date each deficiency has been, or will be, corrected.

4. Sign and date the form(s) in the space provided at the bottom of the first page.

5. Include dates when corrective action will be completed. 42 CFR 488.28 states ordinarily a provider is expected to take the steps needed to achieve compliance within 60 days of being notified of the deficiencies. Please keep this in mind when preparing your plan of correction. For corrective actions which require construction, competitive bidding, or other issues beyond the control of the facility, additional time may be granted.

Sign and date the form(s) in the space provided at the bottom of the first page.

After you have completed your Plan of Correction, return the original to this office by **June 1, 2010,** and keep a copy for your records.

You have one opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an opportunity, you are required to send your written request and all required information as directed in Informational Letter #2007-02. Informational Letter #2007-02 can also be found on the Internet at:

http://www.healthandwelfare.idaho.gov/site/3633/default.aspx

This request must be received by June 1, 2010. If a request for informal dispute resolution is received after June 1, 2010, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

Thank you for the courtesies extended to us during our visit. If you have questions, please call this office at (208) 334-6626.

Sincerely,

MICHAEL A. CASE
Health Facility Surveyor
Non-Long Term Care

NICOLE WISENOR
Co-Supervisor
Non-Long Term Care

MC/mlw

Enclosures

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G045	A. BUILDING _____ B. WING _____	05/06/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDAHO FALLS GROUP HOME #3 PERISKA	950 PERISKA WAY IDAHO FALLS, ID 83405

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 000	INITIAL COMMENTS The following deficiencies were cited during the annual recertification survey. The survey was conducted by: Michael Case, LSW, QMRP Common abbreviations/symbols used in this report are: DOP - Destruction Of Property IDT - Interdisciplinary Team ITTP - Interdisciplinary Treatment Team Plan MAR - Medication Administration Record NOS - Not Otherwise Specified OCD - Obsessive Compulsive Disorder PRN - As Needed QMRP - Qualified Mental Retardation Professional SIB - Self Injurious Behavior	W 000	RECEIVED JUN 01 2010 FACILITY STANDARDS	
W 214	483.440(c)(3)(iii) INDIVIDUAL PROGRAM PLAN The comprehensive functional assessment must identify the client's specific developmental and behavioral management needs. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure behavioral assessments contained comprehensive information for 3 of 3 individuals (Individuals #1 - #3) whose behavioral assessments were reviewed. This resulted in a lack of information on which to base program intervention decisions. The findings include: 1. Individual #1's 12/30/09 ITTP stated she was a 35 year old female whose diagnoses included	W 214	W 214 1. All individuals have the potential to be affected by this practice. All behavior assessments will be revised to contain clear and concise information regarding maladaptive behaviors. Revisions will include analysis of potential causes and information related to what elicited or sustained the behaviors. 2. The QMRP will be responsible for revising all behavior assessments to ensure they contain clear and concise information. The IDT will review all behavior assessments annually during each individuals Treatment Team Meeting. Behavior assessments will also be revised and updated anytime there is a change in any individuals maladaptive behaviors. 3. Target date for completion will be July 6, 2010.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Admin Dsg. 5/25/10

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G045	A. BUILDING _____ B. WING _____	05/06/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDAHO FALLS GROUP HOME #3 PERISKA	950 PERISKA WAY IDAHO FALLS, ID 83405

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 214	Continued From page 1 profound mental retardation and a seizure disorder. Individual #1's Behavioral Assessment, dated 12/3/09, stated she displayed the following maladaptive behaviors: - Inappropriate touch - Self injurious behavior - Physical aggression - Inappropriate verbalizations The Behavioral Assessment did not contain clear and concise information regarding Individual #1's maladaptive behaviors, including information related to analyses of the potential causes, or information related to what elicited or sustained the behaviors as follows: a. Individual #1's Behavioral Assessment defined self injurious behavior as hitting or biting herself. However, inappropriate touch, physical aggression, and inappropriate verbalizations were not defined or described. b. Individual #1's 12/30/09 ITTP stated she received Lexapro (an antidepressant drug) 20 mg daily for anxiety. However, the Behavioral Assessment did not include a diagnosis of anxiety or a definition or description of anxiety. c. Individual #1's Behavioral Assessment included a section titled "Antecedent," which stated "These behaviors happen throughout the day in all settings. Loud noises, not getting enough attention, working with new staff, and shift changes appear to be the main triggers. She also becomes upset if she is unable to have time alone in her room, is taking showers, or is being transferred in the hoyer [sic] lift."	W 214		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G045	A. BUILDING _____ B. WING _____	05/06/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDAHO FALLS GROUP HOME #3 PERISKA	950 PERISKA WAY IDAHO FALLS, ID 83405

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 214	Continued From page 2 There was not a clear relationship between which antecedents were related to which maladaptive behaviors. d. With the exception of "not getting enough attention," Individual #1's Behavioral Assessment did not contain information related to potential factors that were eliciting or sustaining her maladaptive behaviors based upon antecedent data (i.e., escape avoidance, lack of ability to communicate needs and desires, presence of a psychological condition, or other environmental or social conditions). During an interview on 5/6/10 from 9:50 a.m. - 12:15 p.m., the QMRP stated Individual #1's Behavior Assessment needed to be revised. 2. Individual #3's 4/28/09 ITTP stated he was a 48 year old male whose diagnoses included profound mental retardation, intermittent explosive disorder, impulse control disorder NOS, and autism. Individual #3's Behavioral Assessment, dated 12/3/09, stated he displayed the following maladaptive behaviors: - Physical aggression, defined as grabbing, pinching, and pulling hair or clothing. - Food stealing, defined as taking food from other individuals or staff. - OCD behaviors, defined as pacing, repeatedly going to the cupboards, and not wearing an item of clothing that someone has touched first. The Behavioral Assessment did not contain clear and concise information regarding Individual #3's maladaptive behaviors, including information	W 214		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G045	A. BUILDING _____ B. WING _____	05/06/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDAHO FALLS GROUP HOME #3 PERISKA	950 PERISKA WAY IDAHO FALLS, ID 83405

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 214	Continued From page 3 related to analyses of the potential causes, or information related to what elicited or sustained the behaviors as follows: a. Under the "Description of Behavior" section, the Behavioral Assessment stated Individual #3 would engage in physical aggression for attention, to escape/avoid a task, or because he was impatient. Under the "Setting(s) in which behavior occurs" section, the Behavioral Assessment stated Individual #3 would display aggression if he was in pain. However, the Behavioral Assessment did not differentiate how aggression changed dependent upon the noted functions of the behavior listed above. b. Under the "Weaknesses" section, the Behavioral Assessment stated Individual #3 became frustrated when given unclear or complicated directions, when people talked about him instead of to him, or when he was not able to communicate his wants and needs. The Behavioral Assessment stated he did not like working with new staff, changes in his routine, waiting at the doctor, waiting for meals or snacks, and not being able to eat all he wanted. Under the "Setting(s) in which behavior occurs" section, the Behavioral Assessment stated "Behaviors occur in all environments and situations. They tend to increase when he is seeking attention, trying to communicate his wants and needs, or when he is trying to escape/ avoid [sic] a task. He also displays behaviors when he is impatient and wanting something	W 214		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G045	A. BUILDING _____ B. WING _____	05/06/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDAHO FALLS GROUP HOME #3 PERISKA	950 PERISKA WAY IDAHO FALLS, ID 83405

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 214	Continued From page 4 immediately." Further, the Behavioral Assessment stated Individual #3 "also tends to exhibit behaviors when he is anxious about things in his environment." There was not a clear relationship between the antecedents noted above and his maladaptive behaviors. c. Individual #3's 4/28/09 ITTP listed intermittent explosive disorder and impulse control disorder NOS. However, these diagnoses and how they impacted Individual #3's maladaptive behaviors were not addressed in the behavioral assessment. During an interview on 5/6/10 from 9:50 a.m. - 12:15 p.m., the QMRP stated Individual #3's Behavioral Assessment needed to be revised. 3. Individual #2's 2/25/10 ITTP stated he was a 23 year old male whose diagnoses included severe mental retardation, mood disorder NOS, and depression. Individual #2's Behavioral Assessment, dated 2/10/10, stated he displayed the following maladaptive behaviors: - Physical aggression, defined as grabbing, pinching, hitting, kicking, and pulling hair with enough force to cause injury. - Self injurious behavior, defined as hitting himself in the head or mouth. - Property destruction, defined as throwing items. - Invasion of personal space, undefined. The Behavioral Assessment did not contain clear and concise information regarding Individual #2's maladaptive behaviors, including information	W 214		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G045	A. BUILDING _____ B. WING _____	05/06/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDAHO FALLS GROUP HOME #3 PERISKA	950 PERISKA WAY IDAHO FALLS, ID 83405

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 214	Continued From page 5 related to analyses of the potential causes, or information related to what elicited or sustained the behaviors as follows: a. Under the "Description of Behavior" section, the Behavioral Assessment stated Individual #2 "will engage in these behaviors to escape/avoid a task he has been asked, when he wants attention, or when he is not feeling well." Under the "Setting(s) in which behavior occurs" section, the Behavioral Assessment stated "Behaviors occur in all environments and situation. [sic] They tend to increase when he is seeking attention, trying to communicate his wants and needs, or when is is trying to escape avoid a task." However, there was not a clear relationship between the functions of behavior noted above and how they related to each maladaptive behavior. b. Under the "Setting(s) in which behavior occurs" section, the Behavioral Assessment stated Individual #2 "will also display aggression, SIB, and DOP if he is in pain." However, the Behavioral Assessment did not differentiate how the behaviors changed dependent upon the settings noted above. During an interview on 5/6/10 from 9:50 a.m. - 12:15 p.m., the QMRP stated Individual #2's Behavioral Assessment needed to be revised. The facility failed to ensure Individual #1 - #3's behavior assessments contained clear and comprehensive information.	W 214		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G045	A. BUILDING _____ B. WING _____	05/06/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDAHO FALLS GROUP HOME #3 PERISKA	950 PERISKA WAY IDAHO FALLS, ID 83405

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 225	483.440(c)(3)(v) INDIVIDUAL PROGRAM PLAN The comprehensive functional assessment must include, as applicable, vocational skills. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure a relevant and comprehensive vocational assessment was obtained for 3 of 3 individuals (Individuals #1 - #3) who were of working age and for whom such assessments were required. Without a comprehensive assessment, the facility would be unable to assist each individual with their vocational training needs, through the development of objectives designed to optimize their abilities. The findings include: 1. Individual #1 - #3's records included Vocational Assessments that were scored using a rating system (full assistance, light touch, verbal/shadowing, minimal gesture, and no help). The assessments including various skills and scoring consisted of marking the appropriate rating of each skill in one of three categories (has skills, emerging skills, and no skills). Attached to the assessment was a page titled "Narrative Summary of Needs." The assessments did not include information related to work interests, recommendations for improving existing or emerging skills needed for employment, or present and future employment options. During an interview on 5/6/10 from 9:50 a.m. - 12:15 p.m., the Day Program Supervisor and QMRP both stated the assessments did not contain sufficient information and needed to be	W 225	W 225 1. All individuals have the potential to be affected by this practice. All vocational assessments will be updated to include information regarding work interests, recommendations for improving existing or emerging skills needed for employment, or present and future employment. 2. The QMRP and Day Treatment Supervisor will be responsible for updating all vocational assessments to ensure all components of assessment are present to meet regulations. The vocational assessments will be reviewed annually during each individuals Treatment Team Meeting. .Vocational assessments will also be updated anytime there are significant changes in an individuals work related skills. 3. Target date for completion will be July 6, 2010.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G045	A. BUILDING _____ B. WING _____	05/06/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDAHO FALLS GROUP HOME #3 PERISKA	950 PERISKA WAY IDAHO FALLS, ID 83405

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 225	Continued From page 7 updated. The facility failed to ensure Individual #1 - #3's vocational assessments contained specific and comprehensive information related to work interests, recommendations for improving skills, and present and future employment options.	W 225		
W 239	483.440(c)(5)(vi) INDIVIDUAL PROGRAM PLAN Each written training program designed to implement the objectives in the individual program plan must specify provision for the appropriate expression of behavior and the replacement of inappropriate behavior, if applicable, with behavior that is adaptive or appropriate. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure appropriate replacement behaviors were identified and incorporated into the behavior management plan for 3 of 3 individuals (Individuals #1 - #3) whose behavioral interventions were reviewed. This resulted in individuals not receiving training to replace maladaptive behaviors. The findings include: 1. Individual #2's 2/25/10 ITTP stated he was a 23 year old male whose diagnoses included severe mental retardation, mood disorder NOS, and depression. a. Individual #2's record included a Plan Sheet titled "Self Injurious Behavior," dated 3/09, which stated staff were to block his attempts to hit or bite himself. However, the record did not include information related to training he was to receive to	W 239	W 239 1. All individuals have the potential to be affected by this practice. All behavior management plans will be reviewed and revised to ensure appropriate replacement behaviors are identified and incorporated into each behavior management plan. 2. The QMRP will be responsible for reviewing and revising all behavior management plans to ensure appropriate replacement behaviors are identified and incorporated into each behavior management plan. The QMRP will monitor each behavior management plan monthly to ensure replacement behaviors are present and effective. 3. Target date for completion will be July 6, 2010.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G045	A. BUILDING _____ B. WING _____	05/06/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDAHO FALLS GROUP HOME #3 PERISKA	950 PERISKA WAY IDAHO FALLS, ID 83405

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 239	Continued From page 8 appropriately replace his maladaptive behavior. During an interview on 5/6/10 from 9:50 a.m. - 12:15 p.m., the QMRP stated Individual #2 did not have a replacement behavior program for self injurious behavior. b. Individual #2's record included a Plan Sheet titled "Decrease Aggression," dated 1/15/10, which stated staff were to tell him "no" and redirect him to his room to calm any time he engaged in aggressive behavior. However, the record did not include information related to training he was to receive to appropriately replace his maladaptive behavior. During an interview on 5/6/10 from 9:50 a.m. - 12:15 p.m., the QMRP stated Individual #2 did not have a replacement behavior program for aggression. c. Individual #2's record included a Plan Sheet titled "Property Destruction," dated 3/09, which stated staff were to ask him "are you mad?" if he exhibited precursors to property destruction. However, the record did not include information related to training he was to receive to express being mad when he was not engaged in precursory behavior. During an interview on 5/6/10 from 9:50 a.m. - 12:15 p.m., the QMRP stated asking Individual #2 if he was mad was a staff response, and he did not have a replacement behavior program for property destruction. d. Individual #2's record included a Plan Sheet titled "Personal Space," dated 10/07, which stated staff were to tell Individual #2 he was too close if	W 239		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G045	A. BUILDING _____ B. WING _____	05/06/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDAHO FALLS GROUP HOME #3 PERISKA	950 PERISKA WAY IDAHO FALLS, ID 83405

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 239	Continued From page 9 he invaded their personal space. However, the record did not include information related to training he was to receive to appropriately replace his maladaptive behavior. During an interview on 5/6/10 from 9:50 a.m. - 12:15 p.m., the QMRP stated Individual #2 did not have a replacement behavior program for personal space. The facility failed to ensure Individual #2 received training to appropriately replace his maladaptive behaviors. 2. Individual #3's 4/28/09 ITTP stated he was a 48 year old male whose diagnoses included profound mental retardation, intermittent explosive disorder, and impulse control disorder NOS. a. Individual #3's record included a Plan Sheet titled "Decrease Aggression," dated 10/08, which stated staff were to say "no" and redirect him to a neutral area to calm. However, the record did not include information related to training he was to receive to appropriately replace his maladaptive behavior. During an interview on 5/6/10 from 9:50 a.m. - 12:15 p.m., the QMRP stated Individual #3 did not have a replacement behavior program for aggression. b. Individual #3's record included a Plan Sheet titled "Decrease Food Stealing," dated 5/09, which stated staff were to interrupt by placing their hand between Individual #3 and the item he was trying to steal. However, the record did not include information related to training he was to	W 239		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G045	A. BUILDING _____ B. WING _____	05/06/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDAHO FALLS GROUP HOME #3 PERISKA	950 PERISKA WAY IDAHO FALLS, ID 83405

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 239	Continued From page 10 receive to appropriately replace his maladaptive behavior. During an interview on 5/6/10 from 9:50 a.m. - 12:15 p.m., the QMRP stated Individual #3 did not have a replacement behavior program for food stealing. The facility failed to ensure Individual #3 received training to appropriately replace his maladaptive behaviors. 3. Individual #1's 12/20/09 ITTP stated she was a 35 year old female whose diagnoses included profound mental retardation, microcephaly with spastic paraplegia, and seizure disorder. a. Individual #1's record included a Plan Sheet titled "Aggression to Others," revised 2/08, which stated staff were to redirect her to a neutral area when she was physically aggressive. However, the record did not include information related to training she was to receive to appropriately replace her maladaptive behavior. During an interview on 5/6/10 from 9:50 a.m. - 12:15 p.m., the QMRP stated Individual #1 did not have a replacement behavior program for aggression. b. Individual #1's record included a Plan Sheet titled "Decrease Hitting and Biting Self," revised 3/09, which stated staff were to neutrally interrupt hits and bites by blocking with an open hand. However, the record did not include information related to training she was to receive to appropriately replace her maladaptive behavior. During an interview on 5/6/10 from 9:50 a.m. -	W 239		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G045	A. BUILDING _____ B. WING _____	05/06/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDAHO FALLS GROUP HOME #3 PERISKA	950 PERISKA WAY IDAHO FALLS, ID 83405

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 239	Continued From page 11 12:15 p.m., the QMRP stated Individual #1 did not have a replacement behavior program for self abuse. The facility failed to ensure Individual #1 received training to appropriately replace her maladaptive behaviors.	W 239		
W 322	483.460(a)(3) PHYSICIAN SERVICES The facility must provide or obtain preventive and general medical care. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure routine tardive dyskinesia evaluations were conducted for 2 of 3 individuals (Individuals #2 and #3) whose behavior modifying drugs were reviewed. This resulted in the potential for individuals' health needs to not be met. The findings include: 1. Individual #2 and #3's records documented they were receiving behavior modifying drugs which included the following antipsychotic drugs: - Individual #2 received Abilify (30 mg each morning) and Zyprexa (10 mg each evening). - Individual #3 received Risperdal (3 mg twice daily) and Seroquel (800 mg each evening). The Nursing 2010 Drug Handbook stated Abilify, Zyprexa, Risperdal, and Seroquel had potential to cause tardive dyskinesia (repetitive and involuntary muscle movements caused by long term use of antipsychotic drugs) and stated individuals taking these drugs should be	W 322	W 322 1. All individuals have the potential to be affected by this practice. All medication side effects will be reviewed for all individuals and will be evaluated for tardive dyskinesia. 2. The Medical Coordinator and Consulting RN will be responsible for assessing each individuals medication side effects for tardive dyskinesia. Any new medications that are prescribed to any individuals will be reviewed for side effects and monitored for tardive dyskinesia if necessary. Nursing staff will evaluate for signs and symptoms of tardive dyskinesia on a quarterly basis during quarterly nursing assessment. 3. Target date for completion will be July 6, 2010.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G045	A. BUILDING _____ B. WING _____	05/06/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDAHO FALLS GROUP HOME #3 PERISKA	950 PERISKA WAY IDAHO FALLS, ID 83405

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 322	Continued From page 12 monitored for tardive dyskinesia. However, Individual #2 and #3's records did not include documentation of tardive dyskinesia evaluations. During an interview on 5/6/10 from 9:50 a.m. - 12:15 p.m., the Medical Coordinator stated evaluations had not been completed. The facility failed to ensure tardive dyskinesia evaluations were completed for Individuals #2 and #3 who were routinely receiving antipsychotic medications.	W 322		
W 362	483.460(j)(1) DRUG REGIMEN REVIEW A pharmacist with input from the interdisciplinary team must review the drug regimen of each client at least quarterly. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure the pharmacist conducted comprehensive drug regimen reviews with accurate input from the IDT. This directly impacted 1 of 3 individuals (Individual #1) whose pharmacy consultations were reviewed, and had potential to impact all individuals (Individuals #1 - #6) residing in the facility. This resulted in the potential for negative health outcomes due to inaccurate medication documentation. The findings include: 1. Individual #1's 12/30/09 ITTP stated she was a 35 year old female whose diagnoses included profound mental retardation, seizure disorder, and microcephaly with spastic paraplegia.	W 362	W 362 1. All individuals have the potential to be affected by this practice. All physicians orders and medication flow sheets will be reviewed to ensure accuracy. 2. The Medical Coordinator and Pharmacy Review Team will review all physicians orders and medication flow sheets on a quarterly basis during Pharmacy Review Meeting to ensure accuracy of documentation. 3. Target date for completion will be July 6, 2010.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G045	A. BUILDING _____ B. WING _____	05/06/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDAHO FALLS GROUP HOME #3 PERISKA	950 PERISKA WAY IDAHO FALLS, ID 83405

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 362	Continued From page 13 Individual #1's record contained a Progress Notes, dated 9/11/09, which stated Individual #1 was to receive Ibuprofen (an anti-inflammatory drug) 800 mg three times daily and Flexeril (a muscle relaxant drug) 10 mg three times daily PRN for neck pain. Individual #1's MARs, dated 9/9 - 3/10, were reviewed and documented the following: - Flexeril 10 mg was received 26 times in 9/09. - Ibuprofen 800 mg was received 30 times in 9/09. - Ibuprofen 800 mg was received 15 times in 2/10. - Ibuprofen 800 mg was received 4 times in 3/10. Individual #1's Pharmacy Review forms consisted of a grid listing medications, the date prescribed, a check box for "No Problems," and a check box for "Med change or problem." At the bottom of the form were three statements, "Standing orders reviewed," "Medication sheets reviewed," "pharmacy review done," followed by a yes/no check system. However, Individual #1's Pharmacy Review forms, dated 10/28/09, 1/27/10, and 4/28/10, did not include Flexeril or Ibuprofen. Additionally, all three forms indicated standing orders and medication sheets had been reviewed. During an interview on 5/6/10 from 9:50 a.m. - 12:15 p.m., the Medical Coordinator stated MARs were not reviewed by the pharmacist during the pharmacy review process. The Medical Coordinator stated the pharmacist only reviewed the Physician's Recap Orders that were completed by the Medical Coordinator.	W 362		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G045	A. BUILDING _____ B. WING _____	05/06/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDAHO FALLS GROUP HOME #3 PERISKA	950 PERISKA WAY IDAHO FALLS, ID 83405

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 362	Continued From page 14 The facility failed to ensure complete information was present for pharmacy reviews.	W 362		
W 368	483.460(k)(1) DRUG ADMINISTRATION The system for drug administration must assure that all drugs are administered in compliance with the physician's orders. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure all medications were administered in compliance with physician's orders for 1 of 3 individuals (Individual #1) whose medication administration records were reviewed. This resulted in an individual receiving a medication for a condition other than its intended purpose. Findings include: 1. A review of the facility's injury and illness reports, dated 11/1/10 - 5/3/10, documented the following: - 3/12/10 at 8:46 a.m., Individual #1 complained of cramps due to menses. The Medical Coordinator was called and instructed staff to give Ibuprofen (an anti-inflammatory drug), no dose stated. - 3/12/10 at 4:00 p.m., Individual #1 complained of stomach pain and cramps due to menses. The Medical Coordinator was called and instructed staff to give Ibuprofen 800 mg. However, Individual #1's Physician's Recap Orders, dated 4/26/10, did not include the use of Ibuprofen.	W 368	W 368 1. All individuals have the potential to be affected by this practice. All physicians orders and medjcation,flow sheets will be reviewed to ensure accuracy. 2. The Medical Coordinator and Pharmacy Review Team will review all physicians orders and medication flow sheets on a quarterly basis during Pharmacy Review Meeting to ensure accuracy of documentation. 3. Target date for completion will be July 6, 2010.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G045	A. BUILDING _____ B. WING _____	05/06/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDAHO FALLS GROUP HOME #3 PERISKA	950 PERISKA WAY IDAHO FALLS, ID 83405

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 368	Continued From page 15 A Progress Notes, dated 9/11/09, stated Individual #1 had been seen by her primary physician due to neck pain. At that time, the physician ordered Ibuprofen 800 mg three times daily. The order did not include the use of Ibuprofen for menstrual pain. A Physician's Telephone Orders, dated 2/1/10, stated Individual #1 was to receive Motrin (a brand of Ibuprofen) 800 mg PRN for neck pain. The order did not include the use of Ibuprofen for menstrual pain. Additionally, Individual #1's MARs were reviewed from 9/09 - 3/10 and documented the following: - 2/9/10 at 4:00 p.m., Ibuprofen 800 mg given for menstrual pain. - 2/10/10 at 8:00 a.m., Ibuprofen 800 mg given for menstrual pain. - 2/10/10 at 4:30 p.m., Ibuprofen 800 mg given for menstrual pain. During an interview on 5/6/10 from 9:50 a.m. - 12:15 p.m., the Medical Coordinator stated Ibuprofen had been prescribed for neck pain and had not been approved by the physician for use for menstrual cramps. The Medical Coordinator stated Ibuprofen should not have been given for menstrual pain. The facility failed to ensure Individual #1's Ibuprofen was given as prescribed by the physician.	W 368		

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G045	A. BUILDING _____ B. WING _____	05/06/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDAHO FALLS GROUP HOME #3 PERISKA	950 PERISKA WAY IDAHO FALLS, ID 83405

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
MM271	16.03.11.100.04(b) Storage of Toxic Chemicals All toxic chemicals must be properly labeled and stored under lock and key. This Rule is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure all toxic chemicals were properly labeled and stored under lock and key for 6 of 6 individuals (Individuals #1 - #6) residing in the facility. This resulted in the potential for individuals having access to toxic chemicals. The findings include: An observation was conducted at the facility's day treatment program on 5/4/10 from 9:15 - 11:30 a.m. All 6 individuals (Individuals #1 - #6) attended the day treatment program at different times throughout the day, Monday through Friday. During the observation, the following toxic chemicals were found to be unlocked, unmarked, or mislabeled: 1. There was 1 spray bottle marked "bleach" that contained a clear liquid on an unlocked shelf in the main area of the day program, and 1 spray bottle marked "bleach" that contained a clear liquid on an unlocked shelf in the back therapy room. The Day Program Supervisor, who was present during the observation, stated the bottles did not contain bleach but contained a disinfectant spray that the facility mixed. The Day Program Supervisor provided a bottle of concentrate labeled Oxivir Five 16 Concentrate. The MSDS (Material Safety Data Sheet) stated the chemical caused eye irritation, could be mildly irritating to skin, and could be harmful if swallowed.	MM271	MM271 1. All individuals have the potential to be effected by this practice. All toxic chemicals will be properly labeled and stored under lock and key. 2. The Administrator will purchase locking cabinets for each production area. All chemicals will be locked in the cabinets when not in use. The Day Treatment Supervisor will walk through each production area a minimum of twice per day to ensure all chemicals are stored under lock and key. Other nontoxic chemicals will be explored for use of disinfecting surfaces at Grand Teton Service Group. 3. Target date for completion will be July 6, 2010. RECEIVED JUN 01 2010 FACILITY STANDARDS	

Bureau of Facility Standards

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Admin Assign. — (X6) DATE: 5/27/10

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G045	A. BUILDING _____ B. WING _____	05/06/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDAHO FALLS GROUP HOME #3 PERISKA	950 PERISKA WAY IDAHO FALLS, ID 83405

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
MM271	Continued From page 1 The Day Program Supervisor, who was present during the observation, stated the chemicals had never been locked but the bottles should have been properly labeled. The facility failed to ensure all toxic chemicals were properly labeled and stored in locked areas. 2. There were 5 cans of Steriphene Disinfectant spray on unlocked shelves in the main area of the day program, 1 can on an unlocked shelf in the back therapy room, and 1 can on unlocked shelves in each of the three bathrooms of the facility. The MSDS stated the product contained a chemical known to cause cancer, caused substantial but temporary eye injury, was harmful if absorbed through the skin, and could cause respiratory irritation. The Day Program Supervisor, who was present during the observation, stated the chemical had never been locked. The facility failed to ensure all toxic chemicals were properly stored in locked areas. 3. There was an unmarked spray bottle on an unlocked shelf in the main area of the day program. The bottle contained a clear liquid. The Day Program Supervisor, who was present during the observation, stated the bottle contained a disinfectant spray (Oxivir Five 16) that the facility mixed. The Day Program Supervisor stated the chemical had never been locked, but the bottle should have been labeled. The MSDS (Material Safety Data Sheet) stated	MM271		

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G045	A. BUILDING _____ B. WING _____	05/06/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDAHO FALLS GROUP HOME #3 PERISKA	950 PERISKA WAY IDAHO FALLS, ID 83405

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
MM271	Continued From page 2 the chemical caused eye irritation, could be mildly irritating to skin, and could be harmful if swallowed. The facility failed to ensure all toxic chemicals were properly labeled and stored in locked areas.	MM271		
MM380	16.03.11.120.03(a) Building and Equipment The building and all equipment must be in good repair. The walls and floors must be of such character as to permit frequent cleaning. Walls and ceilings in kitchens, bathrooms, and utility rooms must have smooth enameled or equally washable surfaces. The building must be kept clean and sanitary, and every reasonable precaution must be taken to prevent the entrance of insects and rodents. This Rule is not met as evidenced by: Based on observation, it was determined the facility failed to ensure the facility was kept clean, sanitary, and in good repair for 6 of 6 individuals (Individuals #1 - #6) residing in the facility. This resulted in the environment being kept in ill-repair. The findings include: An environmental assessment was conducted on 5/4/10 from 1:50 - 2:45 p.m. During that time the following was noted: - A 12 inch section of caulking was missing behind the kitchen sink along the splash guard, and the remaining caulking was spotted with mold and mildew. - In the kitchen, there was a wooden pull out cutting board that was covered with crumbs and food debris. - There was 1 sauce pan, 2 small skillets, and 1	MM380	MM380 1. All individuals have the potential to be affected by this practice. All employees are responsible for completing a damage report on all repairs that are needed in the facility. The damage report is then turned in to the supervisor for review. The supervisor then submits the damage report to the QMRP for follow-up. 2. All repairs that are needed will be completed by maintenance personnel. Any furniture or house holds items needing repair will be assessed and replaced as needed. The graveyard deep cleaning list will be revised to incorporate dusting of the humidifier. 3. Target date for completion will be July 6, 2010.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G045	A. BUILDING _____ B. WING _____	05/06/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDAHO FALLS GROUP HOME #3 PERISKA	950 PERISKA WAY IDAHO FALLS, ID 83405

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
MM380	Continued From page 3 large skillet with Teflon surfaces that were scratched and peeling. - There were 3 cookie sheets with burned on grease and food debris. - The bottom drawer of the stove was broken from the rails. - The refrigerator in the kitchen was missing the rails from 3 of the door shelves. - The front center support of the couch was broken, causing the couch to sag in the middle. - The wall edge to the right of the living room bay window was missing a 3 inch section of plaster exposing the metal foundation underneath. - A support wedge sitting behind the love seat had a broken zipper exposing approximately 3 feet of foam. - The wall in the hallway had a 6 inch by 6 inch and two 4 inch by 2 inch patched sections of wall that were missing paint. - The window blind in the laundry room had multiple slats that were bent and broken. - Individual #3's dresser was missing a knob and the top drawer was broken from the rails. - A folding chair in Individual #6's bedroom had a 6 inch rip in the vinyl cover. - The bottom drawer of Individual #6's dresser was broken from the rails. - The towel rack in the bathroom shared by	MM380		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G045	A. BUILDING _____ B. WING _____	05/06/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDAHO FALLS GROUP HOME #3 PERISKA	950 PERISKA WAY IDAHO FALLS, ID 83405

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
MM380	Continued From page 4 Individual #1 and Individual #4 was missing paint and finish. - The flooring around the toilet and tub in the hall bathroom was peeling away from the edges and sub-flooring. - The bottom drawer of the sink cabinet in the hall bathroom was broken from the rails. The facility failed to ensure environmental cleaning and repairs were maintained.	MM380		
MM724	16.03.11.270.01(a) Assesments As a basis for individual program planning and program implementation, assessments must be provided at entry and at least annually thereafter by an interdisciplinary team composed of members drawn from or representing such professions, disciplines or services areas as are relevant to each particular case. This Rule is not met as evidenced by: Refer to W225.	MM724	MM724 Refer to W225	
MM730	16.03.11.270.01(d)(i) Diagnostic and Prognostic Data Based on complete and relevant diagnostic and prognostic data; and This Rule is not met as evidenced by: Refer to W214.	MM730	MM730 Refer to W214	
MM735	16.03.11.270.02 Health Services The facility must provide a mechanism which assures that each resident's health problems are brought to the attention of a licensed nurse or	MM735	MM735 Refer to W322	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G045	A. BUILDING _____ B. WING _____	05/06/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IDAHO FALLS GROUP HOME #3 PERISKA	950 PERISKA WAY IDAHO FALLS, ID 83405

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
MM735	Continued From page 5 physician and that evaluation and follow-up occurs relative to these problems. In addition, services which assure that prescribed and planned health services, medications and diets are made available to each resident as ordered must be provided as follows: This Rule is not met as evidenced by: Refer to W322.	MM735		
MM758	16.03.11.270.02(f)(iv) Medication System Monitored The resident's medication system must be evaluated and monitored on a regular basis by a registered nurse and/or a licensed pharmacist. Such evaluations must be done at least every thirty (30) days and records of the evaluation, as well as action taken to correct noted problems, must be kept on file by the facility administrator. This Rule is not met as evidenced by: Refer to W362 and W368.	MM758	MM758 Refer to W362 and W368	
MM855	16.03.11.270.08(c) Training and Habilitation Record There must be a functional training and habilitation record for each resident maintained by and available to all training and habilitation staff which shows evidence of training and habilitation service activities designed to meet the objectives set for every resident. This Rule is not met as evidenced by: Refer to W239.	MM855	MM855 Refer to W239	